

ERROR CODES

APPENDIX A-10(1)

ERROR CODE	MESSAGE	EXPLANATION
C01	NDC/ITEM NUMBER NOT ON FILE	<p>A charge was submitted for an item number which is not in the Drug Manual. Reference records to verify the drug item name. If an incorrect number was submitted, rebill with the correct item number. If a non covered drug was dispensed, see error code C14, Item/Service Not Allowed.</p>
C02	ADDITIONAL INFORMATION REQUIRED	<p>Insufficient information was provided to process the claim for payment. If the charge was for a covered service, submit a new claim with a brief service description shown in Field 24C. Also, attach the appropriate report (Operative, Radiology, Laboratory, Pathology, etc.). If no formal report is available, attach a typed narrative description of the service/procedure.</p> <p>If the charge was for a covered drug item, rebill showing the drug name/form/ strength/quantity in the description area of Field 24C. If additional space is required the information may be attached to the claim.</p> <p>If a noncovered drug item was dispensed, reference the error code C14, Item/Service Not Allowed.</p>
C03	ILLOGICAL QUANTITY	<p>A charge was submitted for a quantity greater than the maximum allowed. If an incorrect item type was entered or the quantity was coded incorrectly, or does not conform to the type of unit listed in the Drug Manual, rebill on a new claim by completing the entire service section with the correct information entered in the appropriate fields.</p> <p>If the billing was correct as to the item number and quantity, rebill on a new claim by completing the entire service section. Attach a separate written statement, explaining the unusual quantity, to the new claim. Submit in DPA 1414, Special Approval Envelope.</p>
C04	PRICING REVIEW	<p>The service section has been temporarily suspended for Department review. Do not rebill. The final status of the service will be reported on a future Remittance Advice.</p>
C06	NDC/ITEM NUMBER INVALID ON DATE OF SERVICE	<p>A charge was submitted with an item number which was not in the Drug Manual on the date of service. Reference the Drug Manual for correct item number. If either the item number or the date of service was submitted incorrectly, rebill on a new claim by completing the entire service section including entry of the correct item number and date of service. If a noncovered drug item was dispensed, reference the error code C14, Item/Service Not Allowed.</p>
C14	ITEM/SERVICE	<p>1) A charge was submitted for a drug not covered by the</p>

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NOT ALLOWED		<p>Department. Drugs not listed in the Drug Manual may be requested through Prior Approval. The following information is needed to facilitate the review of the request: Patient name and address; Recipient ID numbers; drug name (strength, dosage, quantity or package size); diagnosis or medical necessity; name, address and Provider Number of the prescribing physician. If available, the name and address of the dispensing pharmacist. Written requests should be submitted to:</p> <p>Illinois Department of Public Aid Attention: Drug Unit - Prior Approval Post Office Box 19117 Springfield, IL 62794-9117</p> <p>Upon notification that Prior Approval has been granted, a new claim may be submitted by completing the entire service section.</p> <p>2) A charge was submitted for a medical supply or supplies not covered by the Department. <u>Do not rebill.</u></p> <p>3) A charge was submitted for a service not allowed based upon the service description or due to another service billed for the same date. <u>Do not rebill.</u></p>
C16	PROCEDURE NOT COVERED BY IL MEDICAL ASSIST	A charge was submitted for a procedure not covered in the program. <u>Do not rebill.</u>
C17	PLACE OF SERVICE ILLOGICAL	A charge was submitted for a procedure indicating a service not normally rendered in the reported setting. Determine whether the correct procedure code and correct place of service were reported. If incorrect, a new claim may be submitted with the correct information entered. If no error is detected but the physician feels the service was appropriate to the setting, submit a new claim with a letter of explaining the appropriateness of the setting. Submit both in a DPA 1414 (Special Approval Envelope).
C18	ABORTION	A claim was submitted for induced abortion services. Either the

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ERROR CODE	MESSAGE	EXPLANATION
	FORM INVALID/NOT ATTACHED	required Form DPA 2390(Abortion Payment Application) <u>or</u> the form submitted was considered to be invalid. If the claim lacked the certification form, submit a new claim with the form attached. Submit both in a DPA 1414, Special Approval Envelope. If the certification form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected, submit a new claim with the form. Submit both in a DPA 1414 (Special Approval Envelope).
C19	STERILIZATION FORM INVALID/NOT ATTACHED	A claim was submitted for services which required attachment of Form DPA 2189 (Consent Form). Either the claim lacked the required form or the form was considered to be invalid. If the required form was not submitted with the rejected claim, submit a new claim with the form attached. If the required form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected, a new claim must be submitted with the form attached. Submit both documents in a DPA 1414 (Special Approval Envelope).
C20	DIAGNOSIS NOT FROM ICD-9-CM	A claim was submitted with a diagnosis code which is not in the ICD-9-CM Manual. Reference medical records to determine the correct diagnosis and then refer to the ICD-9-CM coding structure. If an incorrect code was reported, a new claim may be submitted.
C26	PRIMARY DIAGNOSIS INFO REQUIRED	A claim was submitted with no primary diagnosis. (Field 24D). A new claim may be submitted which includes the patient's primary diagnosis code from ICD-9-CM.
C31	PROCEDURE NOT ON FILE /FOR DATE	A charge was submitted for a procedure code which is either an invalid code; not a valid code based on the service date; or a valid code which does not appear on Department files. The physician should reference his records to determine if the correct procedure code and date of service were reported. If an incorrect procedure or service date was reported, a new claim may be submitted with corrected information. If information on the claim is correct, the Department should be contacted in regard to a valid code not on file. (See Appendix A-21.)
C32	PROCEDURE ILLOGICAL FOR CATEGORY OF SERVICE	A claim was submitted with a procedure code which is not appropriate for the categories of service allowed for the provider. If an incorrect procedure was submitted, rebill on a new claim using corrected information. If the information submitted on the claim is correct, contact the Department. (See Appendix A-21.)
C33	PROCEDURE	A claim was submitted with a type of service code (Field 23E)

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	ILLOGICAL FOR ROLE	which is inappropriate for the reported procedure or if a claim is submitted for C.O.S. 17 (Anesthesia) and the role code is not H, I, or J, the claim will reject. A new claim must be submitted which includes a type of service code appropriate to the procedure code. Submit a new claim which includes a type of service code appropriate to the procedure code.
C34	PROVIDER TYPE NOT ALLOWED TO BILL DISPENSED DRUGS	A claim was submitted with a charge for a dispensed drug but the provider is not enrolled as a physician. If an error was made in the Department's enrollment process, contact the Provider Participation Unit. Once the error has been corrected, rebill the service by completing a new claim form.
C35	TOS=SURGEON/MODIFIER= SURGICAL ASSISTANT	A claim was submitted with a type of service of 2 or 02 (Surgeon) and the modifier value on the claim is "8" (Surgical Assistant). The claim will reject. A new claim must be submitted with the corrected information.
C47	VALID ACCIDENT/INJURY CODE REQUIRED FOR EMERGENCY SERVICES	A claim was submitted with an emergency service procedure code, but with an invalid or missing accident/injury code in Field 10B, OTHER. A new claim may be submitted which includes an appropriate alpha entry in Field 10B, OTHER. (See Appendix A-12.)
C48	INVALID ACCIDENT/INJURY CODE REQ	A claim was submitted with a procedure code for an Emergency Room visit and place of service "E" (Emergency Room) and Accident/Injury Code not equal to A or P. If an incorrect procedure code was billed, submit a new claim with the corrected information.
C60	DIAGNOSIS CODE NOT ALLOWED	A service charge was submitted for a recipient who is covered by the Basic Health Protection Plan (Category 07) and the Diagnosis Code in Box 24D was 99999 (Diagnosis not listed). Submit a new claim with the specific diagnosis code entered in Field 24D.
C72	MINUTES/UNITS	The Department requires documentation for Assistant Surgeon

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ERROR CODE	MESSAGE	EXPLANATION
	EXCEEDS DEPARTMENT MAXIMUM	Services when the time shown in the Days/Units field is 0480 minutes or more. If documentation is not submitted with a hard copy claim, the service will reject. Review a copy of the claim to ensure that the total number of minutes was entered correctly (4 digit minute format). If the entry was incorrect, rebill on a new claim with the correct time in the Days/Unit field. If the entry in the Days/ Unit field was correct, rebill on a new claim and attach a copy of the Operating Room Record or Anesthesia Record which shows the beginning and ending times for the surgery. Mail to the Department in a DPA 1414 (Special Approval Envelope).
C81	MIXED SERVICES/REBILL SEPARATELY	A hospital provider cannot bill for physician services and Healthy Kids services on the same claim. Services should be separated and new claims submitted.
C82	INVALID MODIFIER FOR SERVICE BILLED	A charge was submitted with an invalid entry in the Modifier (MOD) Field (24c) for one of the the following services: <u>HEALTHY KIDS SCREENING</u> - The <u>only</u> acceptable modifiers are J, K, L, M, N, and X. <u>ANESTHESIA</u> - A modifier <u>must</u> be entered, and the only acceptable values are A through G. (See Appendix A-14 of this Handbook.) <u>LABORATORY TEST OR X-RAY FOR PLACE OF SERVICE E (EMERGENCY ROOM)</u> - When a <u>hospital</u> bills fee-for-service for a laboratory test or x-ray for place of service E, either a T or a P is to be entered as a Modifier. T denotes "Technical component" and P denotes "complete" (technical and professional components). PHYSICIAN PROVIDERS DO NOT USE ANY MODIFIER FOR EMERGENCY ROOM LAB/X-RAY SERVICES. Review the copy of the invoice to determine what value was entered in the Modifier Field. If the service was submitted incorrectly, rebill on a new invoice by completing the entire service section with the correct modifier value.
C84	INVALID NUMBER OF TESTS/ PROCEDURE CODE	A quantity of six (6) or more laboratory tests or x-rays was shown in the Days/Units Field (24F). The physician should review his records and a copy of the invoice to determine whether the service was billed inaccurately. (See Chapter 200, Topics A-223 and A-224.)
C89	NOT PAYABLE	The charge submitted is nonpayable by the Department based on the

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ERROR CODE	MESSAGE	EXPLANATION
	BASED ON MEDICARE DETERMINATION	denial reason reported on Medicare's Explanation of Medical Benefits. Review the list of Medicare Action Codes/Messages to determine whether the service is billable on a Medicaid invoice after Medicare denies payment. (See General Appendix 4). If the denial reason is omitted from the listing, no payment can be made by the Department and a request for review by Medicare may be indicated. If the denial reason is shown on the list and the claim was rejected in error, the Department should be contacted (See Appendix A-21.)
C95	PROCEDURE/ SERVICE MUST BE BILLED ON UB 92 INVOICE	This service was rejected because the hospital billed on a DPA 2360 claim form with a CPT procedure code for a HAR service. Rebill on a UB 92 claim form utilizing an equivalent ICD-9-CM procedure code.
C97	NO PAYABLE SERVICE ON CLAIM/REBILL	The clinic billed for an encounter and for the detail service procedure codes. If none of the detail services are payable, the encounter cannot be paid.
D01	DUPLICATE PAYMENT	A charge was submitted for a service previously paid by the Department. The voucher number on which the previously paid

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ERROR CODE	MESSAGE	EXPLANATION
	VOUCHER XXXXXXXX	<p>service was reported is included in this message. Check payment records to verify that payment has been received. If payment has <u>not</u> been received, review a copy of the claim to determine if the procedure code and date were correctly entered on the rejected claim. As appropriate, rebill on a new claim with the correct data. If the rejected service was a clinical laboratory test or x-ray that was repeated on the same service date, and payment was received for only one (1) test/x-ray, Form DPA 2292 Adjustment should be submitted. (Refer to Appendix A-11). The total number of times the test/x-ray was performed must be shown in Field 20 of the Adjustment.</p> <p>If the rejected procedure code was for a procedure or service, other than a lab test or x-ray, that was done more than once on the same date of service, rebill on a new claim using the appropriate corresponding "unlisted" procedure code. A brief description should be entered in Field 24C and an Operative Report (or narrative description) attached.</p>
D03	INVOICE DOES NOT CONTAIN PROVIDER SIGNATURE	The claim was submitted without a proper signature. Stamped or typewritten signatures are not acceptable. All services have been rejected. Prepare and submit a properly signed claim.
D04	SUSPENDED FOR DEPARTMENT REVIEW	The service has been temporarily suspended for Department review. <u>Do not rebill</u> . The final status will be reported on a future Remittance Advice. This message only appears in Suspended Status.
D05	SUBMITTED LATER THAN ONE YEAR AFTER SERVICE	A charge was submitted more than twelve (12 months after the date the service was provided. The Department will not process claims received more than twelve (12) months after the Date of Service.
D08	CLAIM RECEIPT PRIOR TO BILLING/SERVICE	The claim was submitted with a service date later than the billing date or the billing date is after date of receipt by the Department. If the date of service or billing date was not correctly entered on the original claim, a new claim may be submitted.
D25	UNDEFINED ERROR -- CONTACT DEPARTMENT	The claim was submitted with information which caused an unusual error condition. Contact the Department with details of the submitted claim at the address indicated in Appendix A-21.
D36	PRIOR APPROVED TOTAL QUANTITY	The quantity approved on the prior approval request form has been exceeded. No additional payment can be made.

ERROR CODE	MESSAGE	EXPLANATION
	EXCEEDED	
D74	DUPLICATE OF PENDING CLAIM	This service was processed and found to match another claim in payable status. <u>Do not rebill.</u>
D77	MULTIPLE DATES OF SERVICE ON ERC CLAIM	A claim was submitted for a Rural Health Clinic showing more than one date of service. Each date of service requires its own claim form.
D78	OPTICAL PRESCRIPTION ORDER REQUIRED	A claim was submitted for a Dispensing Fee, but no Optical Prescription Order (OPO) was attached. Submit a new claim for Dispensing Fee and attach the Optical Prescription Order (OPO) with the prescription for the eyeglasses completed.

E01	MISSING RECIPIENT NAME	The claim was submitted with the recipient name field blank. Rebill on a new claim. The exact recipient name entered in first,
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ERROR CODE	MESSAGE	EXPLANATION
		middle initial, last name format as shown on MediPlan Card must be used.
E02	MISSING RECIPIENT NUMBER	The claim was submitted with the recipient number field blank. Rebill on a new claim using the correct recipient number as shown on MediPlan Card.
E03	INVALID RECIPIENT NUMBER	The claim was submitted with either non numeric characters in the recipient number field <u>or</u> more or less than nine (9) digits. Rebill on a new claim using the correct nine-digit recipient <u>number</u> as shown on the MediPlan Card.
E04	MISSING DATE OF SERVICE	The service section was submitted with the date of service field blank. Rebill on a new claim by completing the entire service section including the date of service entered in the MMDDYY format. NOTE: When using the "repeat" indicator in Sections 2-7, the date of service is always required.
E05	INVALID DATE OF SERVICE	The service section was submitted with a date of service format other than MMDDYY. Rebill on a new claim by completing the entire service section including the date of service entered in the MMDDYY format.
E09	MISSING QUANTITY	A claim was submitted with a type of service code which requires an entry in the days/units field (24F). Rebill with a four-digit entry in Field 24D. When billing for anesthesia or assistant at surgery, enter the duration of time in minutes: e.g., the entry for 1 hour and 10 minutes is 0070.
E10	INVALID QUANTITY	A claim was submitted with non-numeric values in the days/units field (24F). Rebill on a new claim with corrected information in the days/unit field. Field 24F should contain a four digit entry.
E13	MISSING PROVIDER NAME	The claim was submitted with the physician name field blank. All services have been rejected. The Remittance Advice has been sent to the physician name on Department files, which corresponds to the submitted physician number. If the physician who received the Remittance Advice did provide the service(s) billed, rebill by completing a new claim including entry of the correct physician name. If the services were not provided by the physician who received the Remittance Advice, the Department should be contacted at the address indicated in Appendix A-21.
E14	REPEAT FOLLOWING DELETED	A repeat indicator was entered in the service section immediately following a service section which was deleted. See Appendix A-1 for proper use of repeat indicators. The entire service section must

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ERROR CODE	MESSAGE	EXPLANATION
	SERVICE	be rebilled on a new claim.
E21	INVALID PAYEE CODE	The claim was submitted with no payee indicated on the claim and no payee is found on the Department's Provider Data Base. A new claim must be submitted with corrected information.
E36	MISSING/INVALID DIAGNOSIS CODE	A claim was submitted with a missing/invalid Primary Diagnosis Code. Rebill by completing a new claim including the correct ICD-9-CM diagnosis code. If the ICD-9-CM code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code.
E53	MISSING/INVALID TOTAL CHARGES	A claim was submitted with a missing or invalid total charge. Rebill on a new claim by completing the entire billing including the Total Charge, Field #27.
E55	MISSING/INVALID PROCEDURE CODE	The claim was submitted with procedure code missing or invalid in the service section. Rebill on a new claim by completing the entire billing including a valid procedure code.
E69	MISSING/INVALID TPL CODE	The claim was submitted with a missing or invalid TPL code. Rebill on a new claim by completing the entire billing including a valid TPL code. Reference General Appendix 9 for appropriate codes.
E70	MISSING/INVALID TPL STATUS CODE	A claim has been submitted with a missing/invalid TPL Status Code. Rebill by completing a new claim with a valid TPL Status Code in Field(s) 37b and/or 38b. See Appendix A-1 for valid TPL Status Codes.
E71	MISSING/INVALID TPL AMOUNT	A claim was submitted with a missing/invalid TPL amount. Rebill by completing a new claim with a valid entry in the TPL Amount Field(s) 37c and/or 38c.
E72	MISSING/INVALID TPL DATE	A claim was submitted with a missing/invalid TPL Adjudication Date. The service(s) may be rebilled on a new claim by entering the TPL Adjudication Date in the MMDDYY format as required. Reference Appendix A-1 (37D) for date to use based on applicable status code.
E73	MISSING/INVALID TOTAL DEDUCTIONS	A claim was submitted where the value of the Amount Paid field is not equal to the sum of the values in the TPL Amount fields (37C and 38C). Rebill all services on a new claim with the correct value in the Amount Paid field.

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ERROR**CODE MESSAGE****EXPLANATION**

E75 MISSING/INVALID BILLING DATE The claim has been submitted with a missing or invalid date in Field 25. Rebill on a new claim including the date in Field 25 in the MMDDYY format.

E85 MISSING/INVALID REFERRING PRACTITIONER NUMBER The claim was submitted with a missing or invalid number in Field 19. Rebill on a new claim including the identifying number for the referring practitioner. Reference Appendix A-1 for details relative to required number.

F01 PAYMENT REDUCED XXXX The charge was reduced to the Department's maximum allowable for the service billed. Do not rebill.

F02 QUANTITY REDUCED TO The drug quantity billed was reduced to the Department's maximum allowable for calculation of reimbursement amount. Do not rebill.

ERROR CODES**ERROR****CODE MESSAGE****EXPLANATION**

	DEPARTMENT MAXIMUM	
F13	NET CHARGE RECOMPUTED	The claim was submitted with an incorrect Net Charge. <u>Do not</u> <u>rebill</u> . Informational message only.
F17	THIRD PARTY SOURCE NOT IDENTIFIED	The claim was submitted with a third party liability amount; however, the source of the TPL payment was not identified. The physician should ensure that future claims submitted to the Department include entry of the source name in field 9 whenever the third party liability code is 999.
F18	TPL AMOUNT GREATER THAN DEPARTMENT MAXIMUM	The claim was submitted showing an amount paid by a third party resource exceeding the Department's maximum for the service. If a billing error was made, the physician may submit Form DPA 2292, Adjustment. If no error occurred, no action is required.
F20	TOTAL CHARGES RECOMPUTED	The claim was submitted with a total charge which does not equal the sum of charges as shown in the service sections. The physician's records should be changed to reflect the correct total charge.
F26	TOTAL DEDUCTIONS RECOMPUTED (\$XXXX.XX)	The sum of the individual TPL amount fields as entered on the claim do not equal the amount shown in total deductions. If an error occurred in the original submittal, submit an adjustment (DPA 2292) as described in Appendix A-11.
F30	NUMBER OF SECTIONS TOTAL IN ERROR	The claim was submitted with an incorrect entry in Field 34. The physician should ensure that future claims include a proper entry to reflect the total number of service sections completed on the claim. <u>Do not include sections deleted</u> . If this message appears <u>BUT</u> one or more services rejected, rebill the specific rejected services after making the necessary corrections to billing information. Do <u>not</u> attach a new Optical Prescription Order (OPO).
F52	EYEGASSES FABRICATED	A claim was submitted for a Dispensing Fee. This message is to notify the Optical provider that eyeglasses have been fabricated by the Department of Corrections and mailed to the Optical provider for Dispensing to the Recipient. <u>Do not rebill</u> ; informational message only.

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ERROR CODE	MESSAGE	EXPLANATION
F53	EYEGASSES NOT FABRICATED	A claim was submitted for a Dispensing Fee. This message is to notify the Optical provider that eyeglasses have NOT been fabricated by the Department of Corrections. Rebill on a new claim with corrected Recipient number.
F54	EYEGASSES NOT FABRICATED EXCEEDS LIMIT	A claim was submitted for a Dispensing Fee. This message is to notify the Optical provider that eyeglasses have NOT been fabricated by the Department of Corrections since eyeglasses were previously fabricated by the Department of Corrections and dispensed within 1 year.
F55	REPLACEMENT PART AUTHORIZED	A claim was submitted with a Service Fee. This message is to notify the Optical provider that a replacement part has been authorized by the Department of Public Aid and that the Department of Corrections will be mailing the part to the Optical provider. <u>Do not rebill</u> ; informational message only.
F56	REPLACEMENT PART NOT AUTHORIZED	A claim was submitted with a Service Fee. This message is to notify the Optical provider that a replacement part has NOT been authorized by the Department of Public Aid and that the Department of Corrections will NOT be mailing the part to the Optical provider. Rebill on a new claim with corrected Recipient number.
F96	X-RAY PROCEDURE REDUCED TO DPA ALLOWABLE	The charge submitted exceeded the Department's allowable for combination x-rays. The physician should review the patient's medical record with the CPT-4 definition of the procedure code entered on the original claim. If a separate x-ray procedure was required because of the nature of the patient's injury/illness, the physician may seek payment reconsideration by submitting a properly completed Form DPA 2292, Adjustment. An entry in Field 20 of Form DPA 2292 must explain the nature of the patient's injury/illness which required a separate procedure.
M55	MISSING PROCEDURE CODE/DRUG CODE	The service submitted was either missing the Procedure Code/Drug Item number or the format was not an 8 character numeric (Drug Item Number) or 5 character alpha/numeric (CPT or HCPCS code).

ERROR**CODE MESSAGE****EXPLANATION**

P02 PROVIDER NOT
ENROLLED FOR
CATEGORY OF
SERVICE

The claim was submitted showing a category of service for the physician has never been enrolled. The Department should be contacted at the address listed in Appendix A-21.

P03 PROVIDER NOT
ENROLLED FOR
CATEGORY OF

A charge was submitted for which the date of service either precedes the effective date of the physician's enrollment or is subsequent to the termination of the physician's participation for the

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ERROR**CODE MESSAGE****EXPLANATION**

	SERVICE ON DATE OF SERVICE	applicable Category of Service. Reference records to verify the correctness of the service date. If an incorrect date was entered, the charge may be rebilled on a new claim. If the service date was properly reported, review the Provider Information Sheet for the correctness of the beginning and ending enrollment dates for the category of service billed. If the dates on the Provider Information Sheet appear incorrect, contact the Provider Participation Unit at the address listed in Appendix A-21.
P04	INVOICE INVALID FOR PROVIDER TYPE	The charge was submitted on other than a DPA 2360, Health Insurance Claim Form OR the DPA 2360 was received from a provider who is not identified on Department files as a physician. The service(s) must be rebilled on Form DPA 2360. If the physician's records show that a DPA 2360 was submitted, the physician is to check his Provider Information Sheet to assure that he is correctly identified on Department records. If the Sheet appears incorrect, contact the Provider Participation Unit at the address listed in Appendix A-21.
P06	PROVIDER NAME DOES NOT MATCH PROVIDER NUMBER	An invoice was submitted with a physician name, other than the name carried on Department files, for the provider number designated. The physician is to review the <u>current</u> Provider Information Sheet for the correctness of both the provider name and number. If a billing error was made in either the name or the number, the service(s) may be rebilled by completing a new invoice. If an error cannot be detected, contact the Provider Participation Unit at the address indicated in Appendix A-9. If the name carried on Department files is in error, the name is to be corrected on the Provider Information Sheet and submitted to the Provider Participation Unit. (See Appendix A-21.)
P07	SERVICE NOT ALLOWED PER DEPARTMENT REVIEW	Claims previously suspended due to an audit, have been rejected. <u>Do not rebill.</u> The physician has been officially notified that participation in the program has been terminated.
P15	REPORTED PAYEE NOT FOUND	The payee code entered on the claim (Field 33) identifies a payee who was not authorized on the date(s) of service. Review the Provider Information Sheet to determine that the desired payee has been properly identified to the Department. The physician may request a change to the listed payee by contacting the Provider Participation Unit at the address listed in Appendix A-21.
P19	SERVICES NOT ALLOWED BY	The Bureau of Comprehensive Health Services caused the services to be suspended for special review and evaluation. The services

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	PROVIDER SERVICES	were then rejected as inappropriate for payment. <u>Do not rebill.</u>
P24	NO DELIVERY PRIVILEGES ON FILE	Procedure code 59420 (Care Before Delivery) was submitted but the Provider Database does not indicate that the physician has either delivery privileges or an agreement with a physician who has delivery privileges. Contact the Provider Participation Unit at (217) 782-0538 to obtain the necessary forms to identify their Delivery Privileges or agreement with another physician who has Delivery Privileges.
P46	PROVIDER NOT ENROLLED FOR VACCINE REPLACEMENT PROGRAM	A service was submitted which was coded for the replacement of a vaccine provided in a Healthy Kids visit. The provider is shown in IDPA files as nonparticipating for the Department of Public Health's vaccine replacement program. The physician must contact and file a certification with the Department of Public Health to participate in the Vaccine for Children Plus program. Once the certification has been approved prior to rebilling, the physician should contact the Department of Public Health at the phone number shown in Appendix A-16 for inquiries related to the replacement program.
P98	DEFAULT PAYEE USED	The claim was submitted with a blank or invalid payee code. <u>Do not rebill</u> ; informational message only.
P99	PROVIDER UNCOLLECTED DEBT/CONTACT DEPARTMENT	The physician has submitted a claim for services when he has an uncollected debt with the Department. The physician should contact the Department at the address listed in Appendix A-21.
R01	NO RECORD OF RECIPIENT NUMBER	An invoice was submitted with a recipient number does not match a number in the Department's eligibility files. Rebill on a new claim including entry of the correct recipient number.
R02	RECIPIENT NAME DOES NOT MATCH RECIPIENT NUMBER	An invoice was submitted with a recipient name, other than the name carried on Department files, as the name of the person to whom the recipient number is assigned. Rebill on a new claim by completing the entire service section including entry of the correct recipient name and number.

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ERROR CODE	MESSAGE	EXPLANATION
R03	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	A charge was submitted for a date of service on which the recipient was not eligible. If an error occurred, service may be rebilled with the correct date of service. If no error occurred, no payment can be made. If the physician can determine from his records that eligibility was verified prior to providing the service, contact the billing consultant at the Department at the address indicated in Appendix A-21.
R05	SERVICE RESTRICTED GROUP CARE RECIPIENT	A charge was made for a service which is the responsibility of the group care facility to provide. The provider may contact the local Public Aid office to obtain the name of the group care facility in which the recipient resides. The provider has the responsibility to seek reimbursement from the facility. <u>Neither</u> the Department nor the recipient (or the recipient's family) has an obligation for payment.
R06	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE/ SPENDDOWN NOT MET	A service was submitted for a recipient who was in Spenddown status on the Date of Service. If the recipient presented a valid MediPlan card which shows that they were eligible on the Date of Service, a copy of card is to be attached to the paper invoice when the service is rebilled. Services which require documentation to be billed/rebilled may not be sent electronically.
R09	PRIOR APPROVAL REQUIRED	A claim was submitted for a service that requires Prior Approval and no Prior Approval is posted on the Department's file. A Prior Approval request should be submitted for this service; once the Prior Approval request has been approved, rebill the service.
R10	SERVICE NOT COVERED FOR RECIPIENT CATEGORY	A claim was submitted for a service to a recipient of General Assistance (Category 07), which is not covered by the Medical Assistance Program. The physician may seek appropriate reimbursement from the recipient for a non-covered service which was provided.
R11	HYSTERECTOMY FORM INVALID OR MISSING	A claim was submitted for a service which required attachment of Form DPA 1977 (Acknowledgment of Receipt of Hysterectomy Information). Either the claim lacked the required form, or the form was invalid. If the required form was not submitted with the original claim, submit a new claim with the form attached. Submit both in a DPA 1414 (Special Approval Envelope). If the required form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected, a new claim must be submitted with the form attached. Submit both documents in DPA 1414 (Special Approval Envelope).

ERROR CODES

ERROR CODE	MESSAGE	EXPLANATION
R16	SERVICES INVALID FOR RECIPIENT SEX	The service provided is not appropriate for the sex of the recipient. Reference records to determine if the original claim showed the correct diagnosis and/or procedure. In addition, to refer to records regarding the recipient number to insure that the correct recipient number was reported on the original claim. If an error in the original submittal is found, submit a new claim which includes the correct information. If no error is found, contact the billing consultant at the address shown in Appendix A-21.
R17	SERVICES INVALID FOR RECIPIENT AGE	The service provided is not appropriate for the age of the recipient. Reference records to determine if the original invoice showed the correct diagnosis and/or procedure. Refer to records to ensure that the correct recipient number was reported on the original claim. If an error is found, submit a new claim which includes correct information.
R18	SUSPENDED FOR NEW BORN ELIGIBILITY REVIEW	The Department is investigating the eligibility of the infant patient reported on a particular claim. <u>Do not rebill</u> . The final status of the service will be reported on a future Remittance Advice.
R29	CARE NOT AUTHORIZED BY PRIMARY PHARMACY	A charge was submitted for a service not authorized by the Primary Care Pharmacy named on the recipient's MediPlan Card. A completed Form DPA 1662 from the Primary Care Pharmacy authorizing services was not attached to the claim. The service(s) may be rebilled by completing a new claim. A completed Form DPA 1662 must be attached to the claim. Refer to Chapter 100, Topic 134 of this Handbook.
R30	CARE NOT AUTHORIZED BY PRIMARY PHYSICIAN	A charge was submitted for a service not authorized by the Primary Care Physician (PCP) named on the recipient's MediPlan Card. A completed Form DPA 1662 from the PCP authorizing services was not attached to the claim. The service(s) may be rebilled by completing a new claim. A completed Form DPA 1662 from the Primary Care Physician must be attached to the claim. Refer to Chapter 100, Topic 134 of this Handbook.
R34	SERVICES TO MENTAL HEALTH RECIPIENT	A charge was submitted for services provided to a recipient institutionalized by the Department of Mental Health and Developmental Disabilities (DMHDD). The physician should

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ERROR CODE	MESSAGE	EXPLANATION
	LIMITED	contact the Regional Office of DMHDD regarding payment.
R35	PART A SERVICE BILL MEDICARE	Department records show that the recipient was eligible for Part A Medicare coverage on the Date of Service. The service submitted did not indicate that it had been previously submitted to Medicare. The Service should be submitted to the Medicare Part A Intermediary/Carrier for processing. If the service was previously submitted to Medicare then a copy of the EOMB is to be attached to the service when it is rebilled. If the service was submitted to Medicare but no response was received please contact the Medicare processor to determine the disposition of the claim.
R36	PART B SERVICE BILL MEDICARE	<p>The service billed was provided to a recipient who has Medicare Part B coverage and the service billed is a Medicare covered service.</p> <ol style="list-style-type: none">1) The service should be billed to Medicare as the primary payor. Services approved by Part B will be electronically “crossed over” to the Department for consideration of coinsurance and/or deductible amounts.2) If the service is denied by Part B for some reason other than “not medically necessary” or “utilization limit exceeded”, a Medicaid claim with the Medicare EOMB attached as documentation may be submitted to the Department.3) If the physician can provide information that Department files are in error concerning recipient or service coverage by Medicare, a letter of explanation and a completed Medicaid invoice should be submitted to the Department in a DPA 1414, (Special Approval Envelope).
R39	RECIPIENT HAS PREPAID FULL SERVICE PLAN	A charge was submitted for services rendered to a recipient who is enrolled with a Managed Care Entity (MCE) with full service coverage. The Department has no obligation for payment for physician services provided to recipients enrolled in an MCE. The physician should contact either the recipient or the local Public Aid office to obtain the name and address of the particular Managed Care Entity with which the recipient is enrolled. It is the physician's responsibility to seek reimbursement from the MCE. If the physician can determine from his/her records that eligibility documents viewed at the time the service was provided did not indicate that the recipient was enrolled in an MCE, contact may be made with the Department at the address indicated in Appendix A-

ERROR CODE	MESSAGE	EXPLANATION
		21.
R40	GROUP CARE ITEM ONLY	This item or service which was billed is restricted for payment to recipients who reside in a Group Care Facility. Department records indicate that the recipient was not a resident of a Group Care Facility on the date of service. The provider should check his records to insure that he billed for the correct service to the correct recipient on the correct date of service. If an error was made the service may be rebilled on a new invoice by completing the entire service section. If the provider believes that the invoice was billed correctly, a new invoice should be completed and sent, along with a letter of explanation, in a DPA 1414 (Special Approval Envelope).
R43	HCPCS PROCEDURE CODE REQUIRED	The procedure code billed is not a valid HCPCS code according to Department files. The service may be rebilled on a new invoice by completing the entire service section using a valid HCPCS Level I (CPT) or Level II/III (alpha/numeric) procedure code.
R45	OBSOLETE CODE - NEW HCPCS CODE REQUIRED	The procedure code billed is an obsolete Level II/III alpha/numeric HCPCS code according to Department files. Reference the coding source used in preparing bills to ensure that the code source used is the most recent. If an incorrect code was used, rebill on a new invoice by completing the entire service section with the correct data. If no error is detected, forward a new invoice with the service section completed and a letter documenting the source of the rejected code to the Department using a DPA 1414 (Special Approval Envelope).
R46	OBSOLETE CODE - SEE CURRENT CPT IV	The procedure code billed is an obsolete CPT IV code according to Department files. Verify that the most recent edition of CPT IV is being used. If an incorrect code was used, rebill the service on a new invoice by completing the entire service section with the correct data. If no error is detected, forward a new invoice with the service section completed and a letter documenting the source of the rejected code to the Department using a DPA 1414 (Special Approval Envelope).
R52	SPENDDOWN INFORMATION DISCREPANCY	A claim was submitted with a date of service on a "Spendedown Met" date and no DPA 2432, Split Billing Transmittal, was attached; or the date, charge or recipient liability amount on the

ERROR CODES

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ERROR CODE	MESSAGE	EXPLANATION
		claim did not match the DPA 2432.
R66	QMB RECIPIENT ONLY NOT ELIGIBLE FOR MEDICAID	The service billed is only payable as a Medicare Crossover claim. The service billed is a covered service by the Department for only a special category of Medicare eligible recipients designated as Qualified Medicare Beneficiaries (QMBs). A claim should be submitted to Medicare Part B. If the service is approved, submit a Medicare Crossover claim to the Department. If the service is not approved by Medicare, no payment can be made.
R79	SERVICE NOT COVERED FOR GA ADULT ONLY CASE	The recipient for whom the service is being billed is shown on the Department's files as being an Adult General Assistance case. The Department will cover only those services which are intended to relieve pain and suffering. No services rejected for this error may be reimbursed by the Department.
R83	RECIPIENT IS ENROLLED IN COUNTY CARE TOTAL HEALTH PLAN	A claim was submitted for a recipient who is enrolled with County Care Total Health Plan. The Department has no obligation for payment of services provided to a recipient enrolled with County Care Total Health Plan. The physician should contact either the recipient or County Care Total Health Plan for clarification. The physician is responsible for seeking reimbursement from County Care Total Health Plan.
R88	PARTICIPATION AGREEMENT NOT ON FILE	The physician billed the service in an electronic format without having a valid electronic enrollment on file. In order to bill electronically, the physician or employing organization must submit a DPA Form 1413 (Agreement for Participation) to the Provider Participation Unit. Once the Provider database has been updated, a new Provider Information Sheet will be sent to the submitter indicating that electronic submittal has been approved and claims can be resubmitted.
R90	DIAGNOSIS INAPPROPRIATE FOR HYSTERECTOMY	A service with a Hysterectomy Procedure Code was submitted with a Diagnosis Code which does not indicate the need for a Hysterectomy. The Medical records for the service should be reviewed to determine whether the use of a Hysterectomy procedure was appropriate. If the procedure code was correct, a new <u>paper</u> invoice must be submitted with an appropriate Diagnosis Code. Each submittal of the hysterectomy procedure code must have a DPA Form 1977 (Acknowledgement of Receipt of Hysterectomy Information) attached.
R91	CARE NOT AUTHORIZED BY PRIMARY CARE	The recipient for whom the service is being billed is involved in the Recipient Restriction Program. All physician, drug, clinic, laboratory and podiatric services must be provided by the primary

ERROR CODES

ERROR CODE	MESSAGE	EXPLANATION
	PROVIDER	care physician or authorized pharmacy or there must be a Form DPA 1662 showing approval for non-emergent services to be provided by other than the primary care provider. If Form DPA 1662 was not attached, a new claim may be submitted with the DPA 1662 attached.
T05	TPL STATUS INDICATES TPL AMOUNT REQUIRED	A claim was submitted with a Third Party Liability status of 01. This indicates a TPL Amount greater than zero should be present. Review the copy of the claim and patient records to determine the results of the Third Party adjudication. Submit a new invoice showing the corrected Third Party status or payment amount.
T10	TPL ADJUDICATION DATE ILLOGICAL	A claim was received which contained a TPL adjudication date later than the date the IDPA claim was prepared. The Department is the payor of last resort and all other payment sources must be exhausted prior to consideration by IDPA. The physician should review the patient's record to verify that the TPL date on the original claim was the actual billing or adjudication date, as appropriate. If an error is found in either the TPL date or the billing date, submit a new claim.

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ERROR CODE	MESSAGE	EXPLANATION
T21	RECIPIENT HAS THIRD PARTY COVERAGE	A charge was submitted for a service covered by a Third Party but no TPL information was reported on the claim. Submit the charge to the Third Party shown directly following this service section on the Remittance Advice.
T32	THIRD PARTY SOURCE NOT IDENTIFIED	A charge was submitted for a service with the unlisted TPL Code (999) and no TPL payment source was entered. The service should be rebilled with the appropriate TPL payment source reflected on the claim. If no TPL code is available, use 999 and enter the name and address of the company in field 9.
T37	TPL EDIT BYPASS PREGNANCY RELATED	Payment is authorized for pregnancy-related services to a client with TPL coverage. Department will contact insurance carrier. No action required. Message is informational only.
T38	TPL EDIT BYPASS PREVENTATIVE SERVICES	Payment is authorized for Preventive services to a client with TPL coverage. Department will contact insurance carrier. No action required. Message is informational only.
T40	MEDICARE BENEFICIARY HAS ADDITIONAL TPL	A claim was submitted for a service covered by a Third Party in addition to Medicare Part B, but no TPL information was submitted with the Crossover Claim. The Third Party should be billed as a secondary payer after Medicare Part B has approved the charges. If the Third Party makes payment and an unpaid amount remains, submit a claim form with the Medicare EOB and a TPL EOB verifying TPL information. If the Third Party makes no payment or no liability is in force on the date of service, submit documentation attached to the claim and EOB submitted for Crossover processing.
U52	SERVICE ALLOWED FOR FQHC/ERC FACILITY ONLY	A claim was submitted by a provider other than an Encounter Rate Clinic (Provider Type 43). If provider type is anything other than an Encounter Rate Clinic, resubmit claims with the correct procedure code.
U53	PROCEDURE CODE NOT ALLOWED FOR NURSE PRACTITIONER	A claim was submitted for a service that a Nurse Practitioner is not allowed to bill. If an incorrect procedure code was submitted, rebill on a new claim using the corrected information.
U54	SERVICE ONLY ALLOWED FOR CHILD	A claim was submitted for a Recipient who is over the age of 21 on the date of service. Refer to your records to ensure that the correct Recipient number was used. If an error is found, submit a new claim which includes the corrected information.

ERROR CODE	MESSAGE	EXPLANATION
U56	ASTC SERVICE INVALID FOR DOCUMENT TYPE	An Ambulatory Surgical Treatment Center billed for a procedure on a DPA 2360 that should have been billed on a UB92. Resubmit claim with proper ICD-9-CM procedure code on a UB92 billing form.
U58	PROVIDER NOT ALLOWED TO BILL SERVICE	A claim was submitted for services that are not allowed for this provider. The Optical Provider must be enrolled with the Specialty code of DPA (Diagnostic Pharmaceutical Agent). If an incorrect procedure code was submitted, rebill on a new claim using corrected information.
U61	SERVICE ALLOWED FOR RHC ONLY	A claim was submitted by a provider other than a Rural Health Clinic (Provider Type 48). If Provider Type is anything other than a Rural Health Clinic, resubmit claim with the correct procedure code.
U62	ANESTHESIA MODIFIER REQUIRED	A Medicare Crossover anesthesia claim was submitted with no modifier on the claim. A new claim must be submitted with corrected information.
V21	INVALID TYPE OF SERVICE/ROLE CODE	A claim was received with the type of service illogical for procedure code. Rebill with correct information entered on the claim. NOTE: Review the back of the DPA 2360 claim form for specific instructions on the type of service/role code.
V22	INVALID ROLE CODE STERILIZATION/ ABORTION CODE	The claim was submitted with an invalid code entry in Field 23E. Reference billing instructions in Appendix A-1 for the correct billing procedure and rebill the service on a new claim.
V23	MISSING/INVALID PLACE OF SERVICE	The claim was submitted with a missing value for place of service. Submit a new, and complete, claim.
V24	MISSING/INVALID PROVIDER	A service section was submitted with a missing entry or an invalid entry in the service line charge field. Submit a new, and complete,

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ERROR CODE	MESSAGE	EXPLANATION
	CHARGE	claim. See Appendix A-1 for instructions regarding numbers and proper spacing.
V25	MISSING/INVALID BALANCE DUE	The claim was submitted with a missing entry or an invalid entry for the balance due field. Submit a new, and complete, claim.
V27	ANESTHESIA REQUIRES MODIFYING UNITS	A charge was submitted for anesthesia service with a missing or an invalid entry in the Modifying Units field. Submit a new, and complete, claim. Refer to Appendix A-1 and Appendix A-14 for proper modifier values and definitions.
W37	INVALID MEDICARE PAYMENT	The Medicare payment amount (Total Deductions field) is not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original Crossover documentation for reprocessing.
W39	INVALID MEDICARE CASH DEDUCTIBLE	The cash deductible amount is not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original Crossover documentation for reprocessing.
W41	INVALID MEDICARE COINSURANCE	The coinsurance amount, as entered, was not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original Crossover documentation for reprocessing.
W42	INVALID	The Medicare Adjudication date was not completed in the correct

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ERROR CODE	MESSAGE	EXPLANATION
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	MEDICARE PAYMENT DATE	MMDDYY format. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original Crossover documentation for reprocessing.
W44	MEDICARE ASSIGNMENT CODE NOT YES	The Assignment field on the Medicare Crossover claim was not completed as "YES". The physician is required to accept assignment on claims billed to Medicare; otherwise the Department cannot assume any patient liability for coinsurance and/or deductible. The original invoice submitted to the Department should be reviewed. If a processing error occurred or there were extenuating circumstances as to why the physician failed to accept assignment with Medicare, resubmit the crossover claim with a letter of explanation to the Department in DPA 1414 (Special Approval Envelope).
X03	ONE INITIAL OFFICE VISIT/ EXAM ALLOWED	The Department will only allow one initial office visit per recipient per physician. Rebill the service using a procedure code for a visit for an established patient.
X04	CONSULTATION DISALLOWED	A charge was submitted for an initial or confirmatory consultation code after payment had previously been made to the same physician for an initial/confirmatory consultation, or a charge was submitted for a follow-up consultation without documentation. Reference Chapter 200, Topic 260 for policy on consultation services. If the repeat initial or confirmatory consultation was done at the request of the attending physician, rebill for reconsideration on a new claim attaching a copy of the consultation report. When the patient's condition requires more than one (1) follow-up consultation, service(s) may be rebilled with a copy of the Hospital Discharge Summary. The documents are to be submitted to the Department in a DPA 1414 (Special Approval Envelope).
X05	HOSPITAL VISIT	A charge was submitted for a hospital visit already paid to another

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DISALLOWED	<p>physician. Payment is not routinely allowed for daily hospital visits by more than one physician. The physician should refer to Chapter 200, Topic 284.2, for the policy statement relative to concurrent care. If the patient's condition necessitates concurrent care, the physician may seek payment reconsideration by rebilling the service on a new claim, attaching a copy of the Hospital Discharge Summary. The documents are to be mailed to the Department in a DPA 1414 (Special Approval Envelope).</p>
X06 SURGICAL PACKAGE PREVIOUSLY PAID	<p>A charge was submitted for a procedure/visit considered a part of the surgical service package, i.e., hospital or office visits following major surgery during the thirty (30) day post-operative period; a follow-up hospital or office visit on the day of a minor diagnostic or therapeutic procedure; a surgical procedure considered an inherent part of another procedure and "incidental" procedures. The physician should refer to Chapter 200, Topic 283, for the policy statement relative to surgery. If the physician believes that the patient's condition required the additional service, he may seek reconsideration of payment by rebilling the service on a new invoice with supporting documentation, i.e., (a) if the visit was a consultation, attach a copy of the consultation report; (b) if the attending physician is submitting post-operative visit charges, attach a statement on the physician's letterhead explaining the nature of the injury or illness <u>and</u> a copy of the Admission History and Physical and the Hospital Discharge Summary. If a surgery code was rejected and payment has not been received for any surgery code(s) for the date of service billed, rebill on a new claim and attach a copy of the Operative Report. Resubmit claim and attachment(s) to the Department in a DPA 1414 (Special Approval Envelope).</p>
X07 MATERNITY CARE PREVIOUSLY PAID	<p>A separate charge was submitted for a procedure/visit/consultation which is not allowed with other billed/paid obstetrical services, or a charge was submitted for a delivery or Caesarean Section which was previously paid to the same or a different physician. Refer to Chapter 200, Topic 290, for the policy relative to maternity care. The physician should review a copy of the rejected claim and medical records to determine if the correct information was shown (procedure code, date of service, recipient name and number, delivering doctor/surgeon's name and Type of Service (T.O.S.) code). If an error is found, rebill on a new claim with the correct data. If the original claim contained the correct information and the physician believes the service should be allowed as a separate charge, he/she may request reconsideration by rebilling the service on a new claim with a statement on the physician's letterhead documenting the need for the service/visit and copies of any pertinent reports. If no payment has been received for the delivery or Caesarean Section, for the date of service on the rejected claim, the physician should review the payment records to determine if the service was</p>

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previously billed and paid under another service date or procedure code, e.g., Caesarean Section performed but vaginal delivery was billed in error and paid. If payment has been received for an incorrect procedure code or service date, submit a Form DPA 2292 (Adjustment) and a refund check or request that a credit be taken. Also, attach a new claim with the correct data and a narrative explanation for the resubmittal. If no payment has been received for the delivery or Caesarean Section for the code/date shown on the rejected claim (or for an incorrect code/date), and the medical records verify that delivery/c-section was done by the physician shown on the claim, rebill on a new claim and attach a copy of the Delivery Room Record or Operative Report and a brief narrative explanation for the resubmittal. Resubmitted claims with attachments are to be mailed to the Department in a DPA 1414 (Special Approval Envelope).

<p>X08 SURGICAL PROCEDURE CONFLICTS WITH PREVIOUSLY PAID SURGERY</p>	<p>A charge was submitted for a previously paid surgical procedure which can only be performed once, i.e., appendectomy, cholecystectomy, or circumcision or a charge was submitted for a "partial" procedure for a service date that is the <u>same</u> or <u>after</u> the service date for a billed/paid "complete" procedure, i.e., a salpingectomy or oophorectomy with or after a complete hysterectomy or a delivery after a hysterectomy, or a charge was submitted for a "complete" procedure for a service date that is the <u>same</u> or <u>before</u> the service date for a billed/paid "partial" procedure, i.e., a total thyroidectomy <u>before</u> a subtotal thyroidectomy. Review the patient's medical records and a copy of the rejected claim to determine if the correct procedure code, service date, recipient name and number were shown. If incorrect information was shown on the original claim, the service(s) should be rebilled on a new claim with the correct data. If correct information was shown on the original claim, the service should be rebilled on a new claim with a copy of the appropriate report to document the service, i.e., Operative Report or Delivery Room Record. The Department will determine if the previously paid service</p>
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was billed in error. Resubmit claim and attachment(s) to the Department in a DPA 1414 (Special Approval Envelope).

X09 LAB PROCEDURE PREVIOUSLY PAID A charge was submitted for a constituent part of another laboratory panel/test billed for the same service date. The physician should review a copy of the claim and the patient's medical records to determine if the correct procedure code and date of service were shown. If either was incorrect, rebill on a new claim with the correct data. If the information on the original claim was correct and all tests were done at the same time of the day, do not rebill as no payment can be made, i.e., code 85007 (WBC) is not allowed when done with 85021 (Hemogram). If the laboratory procedure was done at a separate time of the same day, the physician/laboratory may seek payment reconsideration by rebilling on a new claim. Copies of Lab Test Reports for all services billed for the date of service in question must be attached. Also, a brief narrative must be attached which explains the medical necessity for the test to be done separately. Resubmit claim and attachment(s) to the Department in a DPA 1414 (Special Approval Envelope).

X10 X-RAY PROCEDURE PREVIOUSLY PAID A charge was submitted for a constituent part of another x-ray procedure paid for the same service date. Review a copy of the claim and the patient's medical record to determine whether the correct procedure code and date of service were shown. If either was incorrect, rebill on a new claim with the correct data. If all the information on the original claim was correct and the x-rays were done at the same time of the day, do not rebill as no payment can be made, i.e., code 74220 (Esophagus) is not allowed with 74240 (Upper Gastrointestinal Tract). If the x-ray procedure was done at a separate time of the same day due to the nature of the patient's injury/illness, the physician may seek payment reconsideration by rebilling the service on a new claim. Copies of Radiology Reports for all X-ray services billed for the date of service in question must be attached. Also, a brief narrative must be attached which explains the medical necessity for the x-ray done separately. Resubmit claims and attachment(s) to the Department in a DPA 1414 (Special Approval Envelope).

X12 ONE PSYCHIATRIC Payment has been made to the same or different provider for a psychiatric service (other than Electroconvulsive Therapy-ECT) on this service date.

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ERROR CODE	MESSAGE	EXPLANATION
	VISIT PER DAY ALLOWED	The Department allows only one psychiatric service per day. EXCEPTION: Electroconvulsive Therapy (ECT) is allowed in addition to any other psychiatric service. The physician should review a copy of the rejected claim and the patient's medical records to determine if the correct procedure code and date of service were shown. If all information was correct, do not rebill. If the code and/or date were incorrect, rebill on a new claim with the correct data.
X14	ANESTHESIA SERVICE CONFLICTS WITH PREVIOUSLY PAID ANESTHESIA	Multiple charges were submitted by the same or different anesthesia services for providers for the same date of service. Payment is allowed for only one anesthesia service per <u>operative session</u> . The code for the <u>major</u> surgical procedure is to be billed and the total anesthesia time shown in Field 24F (Days or Units). Review a copy of the claim and the Anesthesia Record to determine if the date of service shown for the rejected code was correct or if multiple surgery codes were billed for the same date of service. If the surgery date for the rejected code was incorrect on the original claim, the service should be rebilled on a new claim with the correct data. If multiple surgery codes were billed for the same operative session and payment was made for one, an Adjustment, Form DPA 2292, should be submitted if the <u>total</u> anesthesia administration time exceeded the time shown on the claim for the paid service. If surgeries were done at separate times of the same day, the rejected service should be rebilled on a new claim with copies of both Anesthesia Records and a brief narrative explanation. If <u>no</u> payment was made and the original claim reflected the correct surgery date and anesthesiologist's name, the service should be rebilled and a copy of the Anesthesia Record attached. Resubmit claims and attachments to the Department in a DPA 1414 (Special Approval Envelope).
X15	VISIT PREVIOUSLY PAID	Payment has been made to this provider for a visit or consultation on this service date under a different procedure code. Payment is not routinely allowed for multiple visits on the same service date. Review the patient's medical record to determine if the correct information (procedure code, date of service, etc.) was submitted on the original claim. If any information was incorrect, rebill on a new claim. If the rejected visit was for a different time of day than the previously paid visit, the physician may seek payment reconsideration by rebilling on a new claim. A narrative explanation of the medical necessity for the service must be attached. The claim and attachment(s) are to be mailed to the Department in a Form DPA 1414 (Special Approval Envelope).
X18	HEALTHY KIDS/CPT IV VISITS CONFLICT	Payment was previously made for a Healthy Kids service (screening visit, follow-up visit, make-up visit) <u>or</u> for a CPT office visit code for the same date of service. Payment is allowed for only one visit, screening or exam for a single recipient on a single service date. The provider should review a copy of the rejected claim and medical records to determine if the correct information was shown on the claim (procedure code, service date,

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recipient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the address shown in Appendix A-21.

X19 IMMUNIZATION PREVIOUSLY PAID Payment was previously made for the same immunization, for this service date. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the address shown in Appendix A-21.

X21 HEALTHY KIDS IMMUNIZATION ONE TIME ONLY Payment has previously been made for this immunization. Healthy Kids immunizations are limited to one occurrence each in a recipient's lifetime. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the address shown in Appendix A-21.

X23 SICKLE CELL TEST ONE TIME ONLY Payment for the Sickle Cell Test is limited to one occurrence in a recipient's lifetime, for the same physician. Refer to the patient's record. The test is allowed only once and may not be repeated. Do not rebill.

X24 RENAL CHARGE DAILY/FULL MONTH PREVIOUSLY The ESRD service rejected due to one of the following reasons:

- The daily or full month code was billed and the same or a different provider was previously paid for a dialysis procedure for the same date of service.
- The full months code was billed and payment was previously made to the same or a different provider for one or more daily ESRD service(s).
- The daily ESRD code was billed and the same or a different provider was previously paid for a full month ESRD service. The provider should review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the

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ERROR CODE	MESSAGE	EXPLANATION
		address shown in Appendix A-21.
X25	COMPLETE PROCEDURE PREVIOUSLY PAID	A charge was submitted for a component procedure and the physician was previously paid for a complete procedure code, e.g., EKG, tracing only, (component procedure) vs. complete EKG (complete procedure). The provider should review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient number, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the address shown in Appendix A-21.
X26	EQUIVALENT PROCEDURE PREVIOUSLY PAID	The physician was previously paid for an equivalent procedure code. The provider should review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient number, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection. Inquiries should be directed to the address shown in Appendix A-21.
X27	COMPONENT SERVICES PREVIOUSLY PAID	The physician was previously paid for a component of the all-inclusive procedure code billed. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, recipient number). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Reference payment records to determine which previously paid service caused the rejection.
X32	ANESTHESIA UNITS EXCEEDS DEPARTMENT MAXIMUM	The Department requires documentation for services when the time shown in the Days/Units field is 0480 minutes or more. If documentation is not submitted with a hard copy claim, the service will reject. Review a copy of the claim to ensure that the total number of minutes was entered correctly (4 digit minute format). If the entry was incorrect, rebill on a new claim with the correct time in the Days/Units field. If the entry is 0480 minutes or more, rebill on a new claim with a correct entry and attach a copy of the Anesthesia Record. Mail to the Department in a DPA 1414 (Special Approval Envelope).
X33	ILLOGICAL QUANTITY FOR	The units/quantity value submitted for the number of tests performed for the Procedure Code identified exceeds the Department's standard. The

ERROR CODES

APPENDIX A-10(33)

ERROR

CODE MESSAGE

EXPLANATION

	TESTS-REBILL WITH LAB/X-RAY REPORT	physician should resubmit the service with documentation to support the units/quantity billed. Documentation may be copies of laboratory/x-ray reports or a signed narrative which verifies that the number billed is correct.
X35	SURGICAL ASSIST TIME EXCEEDS DEPARTMENT MAXIMUM	The Department requires documentation for Assistant Surgeon Services when the time shown in the Days/Units field is 0480 minutes or more. If documentation is not submitted with a hard copy claim, the service will reject. Review a copy of the claim to ensure that the total number of minutes was entered correctly (4 digit minute format). If the entry was incorrect, rebill on a new claim with the correct time in the Days/Unit field. If the entry in the Days/ Unit field was correct, rebill on a new claim and attach a copy of the Operating Room Record or Anesthesia Record which shows the beginning and ending times for the surgery. Mail to the Department in a DPA 1414 (Special Approval Envelope).